PROMOTING HEALTHIER LIVING THROUGH A REDUCTION IN TOBACCO USE AMONG MONTANANS

Developing Tobacco-Free Environments
at the Community Level

May 1993

This plan was produced through the combined efforts of the Montana State Tobacco Control Advisory Committee, a group of concerned health professionals and citizens seeking change in the area tobacco use in Montana.

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EXECUTIVE SUMMARY

The use of tobacco products by Americans continues to be the single most important preventable cause of death in the United States and Montana today. Although rates of smoking in the U.S. declined at a rate of .5 percentage point per year between 1965 and 1985, and 1.1 percentage points per year between 1987 and 1990, this downward trend came to a standstill for the first time in 25 years during 1990 - 1991_1. In Montana, this recent trend was documented through the Behavioral Risk Factor Surveillance System, an ongoing cooperative venture between the Montana Department of Health and Environmental Sciences and the Centers for Disease Control and Prevention. For the first time in over eight years of data collecting activity, there was an increase in the percentage of Montanans who smoke cigarettes as reported in 1991_2 (Table - 1).

TABLE - 1: Smoking Prevalence in Montana By Year
Adults 18 & Over, 1984 - 1991

Source: Montana Behavioral Risk Factor Survey

YEAR	% MALE SMOKERS	% FEMALE SMOKERS	% OF POPULATION
1984	29.5%	28.2%	28.9%
1985	24.3%	24.8%	24.6%
1986	23.4%	22.6%	23.0%
1987	21.3%	23.2%	22.3%
1988	20.7%	18.7%	19.7%
1989	19.7%	19.2%	19.5%
1990	17.3%	21.4%	19.4%
1991	20.9%	21.0%	21.0%
1992	**** Data not available at this time ****		

What had once been a steady decline in total adult smoking rates is now an indication of the need for a change in the manner in which we approach the tobacco use problem in the U.S. and Montana. Subsequent progress will require a multi-faceted approach to health education and behavior modification which focuses on the benefits of non-tobacco use behavior within the context of our surrounding environment. Traditional health education efforts will continue to provide an important avenue for assisting tobacco users and non-users alike in avoiding the health consequences of tobacco use. However, it has become obvious that in order to initiate further declines in the rates of tobacco use, other strategies will be needed. Rather than focusing on the negative health consequences of tobacco use, we will need to begin considering TOBACCO CONTROL STRATEGIES in our efforts to curb the use of this lethal product. Health education is part of this new approach to tobacco control, as is decreasing access to tobacco products by youth, reducing tobacco advertising and promotions, taxation of tobacco products, establishing smoke-free policies and media advocacy tactics. Taken together, these strategies can begin preparing our communities to embrace the concept of a smoke-free society, eliminating tobacco use from our homes, schools, workplaces and communities forever.

The groundwork for this new campaign has already been established, with over thirty years of research documenting the health consequences of tobacco use. In fact, most Montanans, including those who are regular users of tobacco, are aware of these health consequences. It is time we approach individuals at the community level, integrating environmentally and culturally sensitive campaigns into the worksite, school, home, healthcare and other community settings on a more personal level, in order to affect a positive change in tobacco use behavior. Our task is to address the cultural, social and environmental factors associated with tobacco use as well as the addictive nature of the drug nicotine.

Today's comprehensive approach to tobacco control issues will require the participation of a wide variety of community and state organizations. This collaborative effort is needed to effectively resist further increases in the usage rates of tobacco products by Montanans. The Montana State Tobacco Control Plan seeks to activate those organizations who share an interest in controlling tobacco use in Montana and to begin developing the cooperative strategy necessary of change in the area of tobacco use.

CIGARETTES: MONTANA'S LEADING CAUSE OF PREVENTABLE DEATH

Cigarette smoking is the single most important preventable cause of death in the United States and Montana today. In 1991, over 1500 of the 6995 deaths in Montana were attributable to the deadly effects of tobacco use[3]. Nationwide, tobacco related death statistics are staggering, with approximately 434,000 people dying prematurely each year of diseases brought about by cigarette smoking, including 35,000 non-smoking Americans as a direct result of exposure to environmental tobacco smoke[4]. This is far more than the total number of annual deaths associated with AIDS, illicit drug use, alcohol abuse, automobile and airplane accidents, suicide, fires and homicides combined. One out of every five deaths in Montana can be linked to cigarette smoking. Smoking is a major risk factor for diseases of the heart and blood vessels, chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), and cancers of the lung, larynx, pharynx, oral cavity, esophagus, pancreas and bladder[5]. Cigarette smoking is responsible for 18 percent of stroke deaths, 21 percent of cardiovascular deaths, 82 percent of COPD deaths, 87 percent of all lung cancer deaths and 30 percent of all cancer deaths[6]. It should be noted that in men and women under the age of 65 years, cigarette smoking accounts for more than 40 percent of cardiovascular disease deaths. Indeed, cigarette smoking is a real killer.

Hazards associated with the use of cigarettes have been known for quite some time. Since the release of the first Surgeon General's Report On Smoking in 1964, scientific studies have demonstrated the extremely addictive nature of nicotine, exceeding that of heroin or cocaine. Many of these studies have substantiated cigarette smoking as a causal factor in the development of lung cancer, the leading type of cancer death among both men and women in United States and Montana. This should come as no surprise since today's cigarette contains over 4000 chemical compounds, 43 of which are known to be carcinogenic (cancer causing) to humans[5]. More alarming are the amounts of carcinogenic substances found in manufactured cigarettes, at a level many times the federally established limits for human consumption. However, protective standards which apply to food and other consumables do not apply to cigarettes. Also, the tobacco industry is exempt from having to list any of the constituents or by-products of its manufactured cigarettes.

In the past thirty years, the U.S. Surgeon General has released over 20 reports documenting the hazardous effects of tobacco use. The results of thousands of scientific studies were utilized in the writing of these reports. Each of these documents further supports the fact that cigarette smoking is a highly addictive process which leads to much premature death, disease and disability in this country. It has become very clear that in order to affect further change in the current smoking rate, health professionals and concerned citizens will need to focus on the environmental, social and political factors associated with the continued distribution and use of cigarettes and tobacco products, rather than the health implications, which have been previously established and are recognized by nearly the entire population.

SMOKELESS TOBACCO PRODUCTS

Smokeless tobacco products have been in existence for more than 400 years. In the United States, following enactment of several 19th century restrictive (social-related) laws and the introduction and subsequent popularity of manufactured cigarettes in the early twentieth century, use of smokeless tobacco plummeted. Recently however, there has been a resurgence in the use of this product, amounting to over 12 million American users by 1985. In Montana, sales of smokeless tobacco products have skyrocketed, with the sales volume doubling between 1982 - 1992[7]. Recent reporting from the Behavioral Risk Factor Surveillance System (B.R.F.S.S.) - 1991 has indicated that approximately 40 percent of adult males have used smokeless tobacco, with the percentage climbing to over 50 percent among the 18 - 34 year age group. In 1991, approximately 20 percent of adult Montanans in the 18 - 34 year age group used smokeless tobacco on a regular basis. Use by adult Montana females is minimal, somewhere between 1 and 2 percent in 1991. However, a problem exists with the numbers of youth experimenting and using the substance on a regular basis. The 1991 Youth Risk Behavior Survey (Y.R.B.S.) and the 1989 and 1989 Adolescent Health Status Report (A.H.S.R.), conducted by the Office of Public Instruction in cooperation with Montana schools, indicate an increasing proportion of adolescent males and females in grades 9 -12 experimenting and using smokeless tobacco on a regular basis. Y.R.B.S. data from 1991 indicate that approximately 33 percent of males and 7.6 percent of females in grades 9 - 12 have used smokeless tobacco in the past 30 days. This presents a real problem when one considers the extreme addictive and behavior reinforcing nature of nicotine, the ease of availability and the ease of use of smokeless tobacco products. The appeal of smokeless tobacco products are further enhanced by advertising and promotions linked to professional athletes and through the addition of flavorings and sweeteners to make getting started using the products easier than ever.

Like cigarette smoking, use of smokeless tobacco can lead to physical and emotional dependence. Smokeless tobacco products contain a variety of chemical compounds, some of which are carcinogenic and are present in sufficient quantity to cause degenerative and structural changes within the tissues lining the oral cavity. Many of these substances are present in quantities sufficient to be over 100 times the amount allowed in federally regulated foodstuffs such as ham, bacon and other cured meats, beer, etc. Since smokeless tobacco is placed and held between the cheek and gum, it has the potential to cause cancers of the lip, tongue and oral cavity, as well as severe gum and tooth disease. Smokeless tobacco provides a dose of nicotine to the central nervous system comparable to cigarette smoking and elicits a similar addictive response from the user. Current studies are suggesting that nicotine alone, may contribute to the development of many of the same diseases caused by smoking, such as cardiovascular diseases, high blood pressure, stroke, peptic ulcer and problems related to pregnancy.[8]

The use of smokeless tobacco is almost 3 times as prevalent in rural areas than in urban areas[9]. Its use is also different among the various geographical areas of the United States. For instance, usage rates among male adults of the south are three times that of adults in the northeast. B.R.F.S.S. data for 1991 indicate that of those states surveyed, Montana ranks a close second to the state of West Virginia for smokeless tobacco use by adults, 15.29 percent vs. 18.11 percent. These statistics are given for comparison of the entire population of each state. As noted earlier, rates are much higher among certain age groups and between races. In states with a significant Native American population, an overall higher rate of usage generally exists.

ENVIRONMENTAL TOBACCO SMOKE

Recently, much attention has been directed towards the health effects of environmental tobacco smoke, or ETS. ETS is the by-product of the tobacco smoking process, rising from the burning end of the cigarette as well as being exhaled by the smoker. A rapidly growing body of evidence has pointed to ETS as a potential health threat to millions of non-smoking Americans. In fact, ETS has recently been labeled a Group A carcinogen by the U.S Environmental Protection Agency (EPA). Based on the weight of available scientific evidence, the EPA has concluded that widespread exposure to ETS presents a serious and substantial public health impact within the U.S. It is estimated that over 3000 lung cancer deaths occur each year in non-smoking adults due to exposure to ETS. The EPA formally released these findings in the document Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders, on January 7, 1993. The EPA is not the first and only government agency to release a formal document on the hazards of ETS. In June 1991, the National Institute of Occupational Safety and Health (N.I.O.S.H.) released a formal report indicating that it was labeling ETS a Class-A carcinogen. In their report, N.I.O.S.H. provided facts related to worker exposure to ETS and methods for its removal from the workplace.

In addition to its cancerous properties, ETS causes up to 300,000 lower respiratory infections (pneumonia and bronchitis) in U.S. infants and children younger than 18 months of age. ETS also causes problems in asthmatic children with up to 1,000,000 children per year experiencing an increase in the number and severity of their asthmatic attacks and symptoms due to the presence of ETS in the home and public buildings. Each year, U.S. mothers who smoke at least 10 cigarettes a day, actually cause up to 26,000 new cases of asthma among their children$_{10}$. Recent survey responses indicate that at least 4.5 million U.S. workers experience great discomfort from exposure to ETS in the workplace.

Environmental tobacco smoke is a real threat to the health and well-being of our citizenry in Montana. Of particular importance, are the effects of ETS on the elderly and the very young, ie. those with compromised or developing respiratory systems. There exists a great need to educate the public regarding the negative health effects associated with repeated exposure to ETS by children and the elderly alike. ETS is a substance which has varying effects upon individuals, some are more physically tolerant than others, but the threat of disease caused by this airborne particulate is real and must be considered.

TARGET GROUPS

(1) Youth Age 18 and Under

Although the hazardous effects of smoking have been documented for over 40 years, this has not helped sway the over 3000 American teenagers who begin smoking tobacco each and every DAY. In Montana, for all students, the median age of first use of cigarettes is age 12. Montana students have self-reported that 21.8 percent smoke cigarettes regularly[11]. The decision to smoke is also predominantly made during the teenage years, with over 90% of current smokers beginning their habit before age 21[12]. From the standpoint of preventive health, tobacco use is clearly a problem of our youth.

Historically, smoking rates among teenagers decreased from 1965 to 1980, leveling off between 18 - 21 percent. One of the problems associated with use of tobacco products by youth lies within the addictive properties of nicotine. The other is in the inability of most youth to gauge the addictive qualities of cigarettes and smokeless tobacco products. For example, of those teens who have given some thought to quitting smoking, 86% have tried to quit at least once but were unsuccessful. Y.R.B.S. data gathered in 1991 indicate that nearly 60 percent of youth smokers attempted to quit within the past 6 months, lending support to the fact that youth underestimate the powerfully addictive nature of tobacco products.

The addictive property of nicotine is no secret to tobacco companies, who currently spend $4 billion dollars per year advertising and promoting their products through glamorous and exciting media campaigns, mostly directed at adolescent boys and girls. They have achieved their financial objectives by preying upon the vulnerability of their target markets (youth) and by "pushing" this highly addictive drug through legal means. It is a known fact among most smokers that it is very difficult to quit when one finally comes to realize the adverse health consequences of tobacco use. This constant cycle of advertising, social acceptance, availability and addiction which results in the continual use of tobacco products is what must be addressed with future tobacco control efforts.

(2) Adults

50 percent of adult Montanan's have smoked at least 100 cigarettes in their lifetime. 73 percent of current and former smokers consume 1 pack or less of cigarettes a day, 17 percent smoke between 1 and 2 packs a day, and roughly 1.5 percent smoke more than 2 packs a day. In 1991, 21 percent of the adult Montana population smoked cigarettes on a daily basis.

Approximately 40% of Montana men have used or tried smokeless tobacco products. Generally, use has been highest among young males in the 18 - 34 year age category.

Unlike cigarette smoking, use of smokeless tobacco products is fairly consistent across all education and income levels. In Montana, 1991 BRFSS data report that 15.3 percent of males were regular users of smokeless tobacco products. Montana currently ranks second in the nation for smokeless tobacco use (behind WVa - 18.1 percent).

(3) Females of Childbearing Age

Females of childbearing age pose a special problem for public health education efforts regarding tobacco use. Y.R.B.S. data for 1991 indicate that 24 percent of Montana females in grades 9 - 12 smoke cigarettes and another 7.6 percent use smokeless tobacco on a regular basis (within the past 30 days). B.R.F.S.S. data for 1991 indicate that 14 percent of 18 - 24 year olds, 31 percent of 25 - 34 year olds and 24 percent of 35 - 44 year olds currently smoke cigarettes (Table - 2).

Table - 2: Current Smoking Status
Montana Females of Childbearing Age, 1991

Source: Montana Behavioral Risk Factor Surveillance Survey

AGE GROUP	% WHO SMOKE
15 - 18	23.9%
18 - 24	13.9%
25 - 34	30.9%
35 - 44	24.1%

Women who smoke while pregnant greatly increase the likelihood of a low birth weight baby, a pre-term underdeveloped baby, and having their baby die of sudden infant death syndrome - S.I.D.S.[13] Lactating mothers can also transmit harmful chemicals to their babies through breastmilk. In addition to the health effects on the developing and nursing baby, women of childbearing age who have young children expose them to ETS within the home environment. Women who smoke 10 or more cigarettes per day with children in the home cause up to an additional 26,000 new cases of asthma annually.

(4) Blue Collar Workers

Smoking prevalence has been shown to be consistently higher among those with less than a high school diploma or who have not attended or graduated from a post-secondary school. This is also reflected in a lower prevalence of tobacco use among those earning incomes in excess of $25,000.00 per year.

Blue collar workers are generally exposed to a greater number and concentration of air-borne contaminants within the workplace, due to the nature of their work. This added exposure, combined with regular cigarette smoking, augments the development of acute respiratory illness and chronic disease. With over 65,000 Montanans employed in blue collar occupations, a large number of these workers could be

reached through the workplace.

(5) Native Americans

Native Americans appear to have the highest prevalence of cigarette smoking among any race[14]. However, lung cancer rates of the Native American population are noted to be low compared to U.S. rates in general. Explanations for this relationship exist in the fact that a high percentage of Native Americans die prematurely of intentional and unintentional injuries (24%), much higher than the national average. The unique environmental and social conditions of Native Americans may result in far more premature deaths at an early age than the U.S. average. Premature death in this case would result in a Native American habitual smoker dying before being diagnosed with lung/oral cancer.

CHANNELS OF DELIVERY

Comprehensive smoking control initiatives consist of several interrelated elements: the target groups which we intend to reach, the channels through which to reach them, and the specific strategies and tactics used to facilitate and sustain change in our target groups. The channels selected for the Montana Tobacco Control Plan have been chosen for their ability to provide access to each of the selected target groups.

Schools provide an excellent opportunity to address the needs of youth in regards to tobacco control issues. For example, health education (prevention) curricula and cessation programs can be integrated into the school environment. Smoke-free policies within the school can also provide reinforcement for the non-use of tobacco products. Worksites provide an appropriate avenue for reaching the majority of adults, including blue collar workers. Health care settings provide opportunities to counsel and educate those patients who are ill from tobacco-caused disease or others such as pregnant women, in an authoritative environment. The community setting provides a necessary mix of opportunities for reaching those who can not be reached through other channels, such as the unemployed, non-working spouses and college students for example.

The following are the channels to be used and some examples of strategy to be performed under the Montana Tobacco Control Plan:

(1) Schools
- a. environmental tobacco policy development
- b. tobacco use health education curriculum
- c. voluntary cessation programs

(2) Worksites
- a. environmental tobacco policy development
- b. voluntary tobacco use health education program
- c. cessation program referrals

(3) Health Care Settings
- a. environmental tobacco policy development
- b. physician and dentist - patient counseling
- c. in/outpatient education and cessation services
  - hospitals, health clinics, W.I.C., etc

(4) Community
- a. environment
  - local tobacco control ordinances
  - advertising and promotional campaigns
- b. network activities

- agencies providing tobacco education/cessation services to the target audience

STRATEGIES TO CONTROL THE USE OF TOBACCO PRODUCTS

(1) Control of Access To Tobacco Products By Minors

In April 1993, H.B. 548, a bill created to restrict access to tobacco products by minors was signed by the governor of Montana. This act requires a license for the retail sale of tobacco products, requires the posting of signs in retail outlets acknowledging the act, prohibits the sale of tobacco products which are not in a sealed and stamped package, prohibits the sale of tobacco products to minors through vending machines and prohibits the use of tobacco products on school grounds. The enactment of H.B. 548 has taken us a step closer towards controlling the use of tobacco products among Montana's youth, a principal target group of our tobacco control strategies. However, additional strategies will be required to support further reductions in tobacco use by Montana youth.

Although H.B. 548 is a necessary component of current and future tobacco control efforts in Montana, enforcement and management of the new law will require combined cooperative effort between selected organizations, agencies and businesses. Enforcement of the new law cannot be overlooked as it has in many states. For example, in 1990, although 44 states and the District of Columbia had youth access laws in effect, only 6 of the states and the District of Columbia had enforcement provisions for these laws. For the youth access to tobacco control act to be effective in deterring youth from purchasing and retailers from selling tobacco to youth, enforcement will play a critical role in the process. Obviously, a reduction in smoking initiation will be more effective than cessation efforts in controlling overall tobacco use.

As part of the ADAMHA (Alcohol, Drug Abuse and Mental Health Administration) Reorganization Act of 1992, under the auspices of the "Synar Amendment", the Secretary of the U.S. Department of Health and Human Services has requested that each state furnish an annual report which documents the activities and accomplishments carried out by the state in enforcing the state's youth access to tobacco law. This is to begin in the budget year 1994.

Strategy One

Conduct periodic, unannounced merchant compliance checks to determine where tobacco products are being illegally sold.

a. Arrange an educational hearing and general briefing to city council members on the means by which youth are being sold tobacco products.

b. Arrange an editorial board briefing on the lack of enforcement of laws restricting access to tobacco products by minors.

c. Organize boycotts of those retailers who will not comply with the tobacco control act.

d. Contact radio/television stations and suggest an interview with an expert on access and availability of tobacco products to minors.

Strategy Two

Provide school teachers and administrators with information on the youth access to tobacco problem and ask them to enforce the law.

Strategy Three

Provide a press kit to each school newspaper editor suggesting editorials in support of tobacco control.

(2) Reducing Tobacco Advertising and Promotion

Placing restrictions on the advertising and promotion of tobacco products is an effective way to reduce its demand. Since the banning of broadcast advertising of tobacco products in 1971, expenditures and promotions for tobacco products has reached an all-time high of nearly 4 billion dollars per year, approximately 15 dollars for every man, woman and child in the country. The focus of today's tobacco advertising campaigns is on reinforcing the social acceptability of tobacco use. This is accomplished in a variety of ways but the most popular seems to be through appealing to the raw senses of the individual: masculinity and aggressiveness for males and popularity and appearance for females. To date, our youth have been very susceptible to this type of coercion and have responded by initiating the use of cigarettes and other tobacco products at alarming rates (over 3000 youth smoke for the first time each day). Tobacco advertising and promotional campaigns are very appealing to a particular segment of our population and their presence undermines tobacco control efforts through contributing to those social pressures which influence young people to start smoking and inhibiting the decision of smokers to quit.

Control of tobacco advertising and promotion requires different tactics because much of the advertising is part of interstate commerce and cannot be banned by any one state. At the federal level, there are substantial constitutional and congressional limits as to what a state can and cannot do in regards to restricting advertising of any product, including tobacco products. However, there are some tactics involving state and community action which can be successful at barring product sampling or advertising in or on state operated transportation, billboards and facilities.

Strategy One

Organize a letter writing campaign urging state or local newspapers and magazines not to accept tobacco advertising.

Strategy Two

Provide assistance in locating alternative financial support and sponsorship to those community groups serving target populations that have become dependent upon tobacco support.

Strategy Three

Organize counter-demonstrations to tobacco industry sponsored events, such as the Doctor's Ought To Care (DOC) "Emphysema Slims" tournaments designed to counter Virginia Slims tennis promotions.

Strategy Four

Distribute to health care providers decals to be applied to magazine covers in waiting rooms, criticizing those magazines which continue to accept cigarette advertising.

Strategy Five

Stage a statewide poster contest for schools focusing on countering tobacco advertising themes. Award prizes for overall winners and obtain publicity of the event.

Strategy Six

Contact those business who provide support or sponsorship along with the tobacco industry and encourage them to adopt a policy against this type of activity.

(3) Development of Tobacco Pricing Policies

Price increases provide another practical method of decreasing consumption of tobacco related products. Studies have shown that for every 10 percent price increase, a 4 percent drop in general consumption occurs. This price elasticity ratio is quite different for youth, who tend to be more sensitive to pricing increases. For this group of consumers, every 10 percent increase in the retail price constitutes an approximate 14 percent drop in consumption. As can be seen, pricing policy can be a very important addition to an overall package of tobacco control measures.

Generally, the public supports increases in tobacco excise taxes, especially when there is a choice between various tax increases such as sales tax, property tax and selected excise taxes. The lack of advocacy in the United States for significant increases in tobacco excise taxes has undermined tobacco control efforts of the past. In order to make serious gains in the non-use of tobacco products, we must continue to strive for higher taxes on tobacco products. As an example, in Norway, a pack of cigarettes will cost a smoker $8.74. More importantly, is the fact that we increase the proportion of taxes collected for each pack of cigarettes sold. The United States ranks last among the industrialized countries in taxing tobacco products. New Zealand, for example, collects 77 percent of the price of a pack of cigarettes in taxes. Compare this with approximately 25 percent per pack in the U.S.

A last comment on tobacco excise taxes. Percentage increases in taxes may not be as effective as one might hope. A 50 percent increase in an 18 cent wholesale level tax (9 cents) may not be felt severely at the consumer level. Past experiences have taught us lessons in initiating larger "cent" increases in the excise tax. Case point: The current Aggressiveness administration recommendation of a $2.00 per pack increase. In theory, a price increase at this level would probably decrease consumption by 40 percent, lowering the percentage of smokers in the U.S. from a current 25.5 percent, to around 15 percent. The potential for the number of lives and health care expenses saved, as well as revenues generated, would be staggering. Advocates can exploit the fact, therefore, that increasing tobacco taxes is a comparatively popular tax/revenue-raising option.

Strategy One

Disseminate data that have been gathered regarding the health effects of tobacco use, the impact of substantial tobacco tax increases, and public support for such measures to educate policymakers to the value of substantially increased tobacco taxes.

Strategy Two

Educate community leaders, business leaders, educators, health care providers, PTA's, minority and women's group leaders and others to support substantial tax increases on tobacco products.

Strategy Three

Educate media gatekeepers to editorialize in support of substantial tax increases on tobacco products.

(4) <u>Encouraging the Development of Smoke-Free Policies</u>

The elimination of environmental tobacco smoke (ETS) from areas where others may

face involuntary exposure and associated health risks is an important component of tobacco control efforts. The recent release of an Environmental Protection Agency document entitled Respiratory Health Effects of Passive Smoking should encourage many employers and facility managers to consider the legal issues which may surround exposure related illnesses. The health implications of breathing ETS have been documented in recent research, with the latest estimates of the numbers of U.S. citizens who die from disease brought on through exposure at 58,000. Most of these deaths are attributable to heart disease and lung cancer.

Smoke-free policies provide more than a safe, tolerant work, home and public environment. Smoke-free policies also serve to provide an environmental stimulus to cessation efforts of those who smoke. Smoke-free policies also discourage initiation or continuance of a smoking habit due to a decrease in social acceptance. The dramatic increase in smoking control legislation over the past several years has begun to change public attitudes and perception of cigarette smoking as we are beginning to see more and more smoke-free areas in our places of work, homes, schools and other public gathering places.

Strategy One

Educate and inform public authorities with regulatory power to implement smoke-free policies within their scope of authority, providing detailed information on legislative steps taken in other jurisdictions to create smoke-free environments and, where legislation already has been introduced, providing supporting materials.

Strategy Two

Educate property owners and managers of the need to voluntarily implement smoke-free policies on their premises.

Strategy Three

Link up with the American Cancer Society's "Great American Smokeout" and provide a community "no smoking day", including the distribution of model smoke-free policies to businesses, restaurants, schools and civic groups.

Strategy Four

Establish a consulting relationship with the various union leadership for implementing worksite smoking policies consistent with their collective bargaining concerns.

Strategy Five

Through workshops or other means, encourage the voluntary adoption of smoke-free policies on the premises of day-care centers, preschools, and other places frequented by young children. Provide information to parents on the dangers of environmental tobacco smoke on young children.

Strategy Six

In health care clinics serving target populations, display posters and distribute information dramatizing the dangers of environmental tobacco smoke and the need for smoke-free environments.

Strategy Seven

Encourage health care providers to speak with each of their smoking patients about the danger they may be posing to those who live and work around them.

Strategy Eight

Educate parents and their families regarding the negative health impact of environmental tobacco smoke in the home and the automobile.

(5) Creating Change Through Health Education

The majority of Montanans realize the health implications of cigarette smoking. A large portion are also aware of the consequences of using smokeless tobacco. The fact remains that tobacco products are legal substances and through tremendous advertising campaigns, the social acceptability of tobacco use remains fairly intact for a particular group of our state's population.

Health education can assist in the eradication of tobacco products from the state of Montana in a variety of ways. One of the most important is through education of our children, BEFORE the age of experimentation and regular use. Another is through providing behavior modification techniques to those youth and adults who desire to quit using tobacco. A third is through the use of mass media to keep the general public aware of the hazards of tobacco use and to criticize and deglamorize the advertising campaigns of the tobacco companies. These strategies, taken together, can go a long way to educating and changing existing tobacco use behavior among Montana citizens.

Strategy One

Promote understanding of the benefits of quitting smoking. Prepare a series of public service announcements recording the voices of former smokers who describe the expected and unexpected benefits of quitting.

Strategy Two

Expose the nature and intent of tobacco industry advertising, promotion, philanthropy, political action and their selected target markets through involving those target markets in radio and print media campaigns denouncing tobacco advertising campaigns.

Strategy Three

Provide a statewide smoking cessation program utilizing one of the cable access channels and materials from a voluntary non-profit health organization.

Strategy Four

Provide curricula within the state school system to be used with children beginning in the 3rd grade and continuing through high school.

Strategy Five

Provide tobacco use curricula for use within the established D.A.R.E., Headstart and Early Childhood programs statewide.

Strategy Six

Provide training to Women, Infants and Children (W.I.C.) clinicians in a smoking cessation education and counseling program for their clients.

Strategy Seven

Utilize existing media campaigns such as "Keep It Together", Red Ribbon Campaign and pre-recorded videotape media which can be "re-tagged" with a toll-free Montana number for people to respond.

Strategy Eight

Work with the Montana Medical Association, the Montana Dental Association and the Montana Association of Respiratory Care in providing materials and information for health care providers to provide counseling and information to their patients.

Strategy Nine

Provide training to school nurses, counselors and/or health educators throughout the state in a tobacco cessation curriculum for use with youth at schools.

SUGGESTED RISK REDUCTION AND SERVICES/PROTECTION OBJECTIVES

(1) YOUTH (AGE 18 & UNDER)

-- Risk Reduction --

1.1 Reduce the percentage of youth age 18 and under who regularly smoke cigarettes from 22% in 1991 to 10% by the year 2000, a decrease of approximately 50%.

1.2 Reduce the percentage of youth in grades 7 - 12 who regularly use smokeless tobacco products:

a) Males -- from 33% in 1991 to 16% by the year 2000, a decrease of approximately 50%.

b) Females -- from 8% in 1991 to 4% by the year 2000, a decrease of approximately 50%.

-- Services & Protection Objectives --

1.3 Enact a state law which restricts the distribution of tobacco products to youth under the age of 18 through retail sale, vending machine sales and product sampling activities by October 1, 1994.

1.4 Establish tobacco-free environments within 100% of the public school system facilities: elementary, middle, secondary schools by September 1, 1996.

1.5 Establish tobacco-free environments within 100% of the licensed daycare facilities in the state by September 1, 1996.

1.6 Provide tobacco use health education and disease prevention curricula within 100% of the public school system: elementary, middle, secondary schools, by the year 2000.

a) 75% of the public school system by September 1, 1997

b) 100% of the public school system by September 1, 1999.

1.7 Begin providing for voluntary cessation programs in the public school system: elementary, middle, secondary schools, by September 1, 1994.

(2) FEMALES OF CHILDBEARING AGE (12 - 44 YEARS)

-- **Risk Reduction** --

2.1 By the year 2000, increase the rate of smoking cessation during pregnancy so that at least 80% of the women who are cigarette smokers at the time they become pregnant quit smoking early in the pregnancy and maintain abstinence throughout the pregnancy.

2.2 Reduce the percentage of W.I.C. clients who smoke (adult females) from 37%, in 1991 to 15%, by the year 2000.

-- **Services & Protection Objectives** --

2.3 Continue providing smoking cessation training and ongoing support to W.I.C. clinicians statewide, attaining an operational status of 100% of the clinics by the year 2000.

(3) ADULTS (OVER AGE 18)

-- **Risk Reduction** --

3.1 Reduce the percentage of adults who smoke from 21% in 1991 to 15% by the year 2000, a decrease of approximately 30%. This is a goal of Healthy People 2000.

3.2 Reduce the percentage of male adults who use smokeless tobacco products from 15% in 1991 to 7% by the year 2000, a decrease of approximately 50%.

-- **Services & Protection Objectives** --

3.3 Enact a comprehensive state law on clean air which prohibits or strictly limits smoking in the workplace and in public places by November 1, 1995.

3.4 Increase to at least 75 percent the proportion of worksites with a formal smoking policy that prohibits or severely restricts smoking at the workplace by the year 2000.

3.5 Provide for tobacco use health education, disease prevention and cessation programs within post-secondary technical schools. 100% compliance by the year 2000.

3.6 By the year 2000, increase to at least 75% the proportion of primary care physicians and dentists who routinely advise tobacco cessation and provide assistance and follow-up for all of their tobacco-using patients.

3.7 By year 2000, 100% of all public health clinics, outpatient clinics and acute care inpatient facilities will have smoke-free policies which are enforced.

3.8 Develop an ongoing series of annual statewide media campaigns directed at each of the adult target audiences to begin by January 1994.

(4) NATIVE AMERICAN POPULATION

-- **Risk Reduction** --

4.1 By the year 2000, reduce smoking prevalence to no more than 15% of the Native American population.

4.2 By the year 2000, reduce the prevalence of use of smokeless tobacco to no more than 10%.

-- **Services & Protection Objectives** --

4.3 Provide all reservation-based schools in Montana with a tobacco use related curriculum for use by instructors by November 1995.

4.4 Develop two targeted media campaigns directed at specific tribal customs and the use of tobacco products for each reservation in Montana by December 1996.

POLICY AND PROGRAM RECOMMENDATIONS FOR THE FUTURE

A. **Enact a state law which restricts the sale and distribution of tobacco products to youth under the age of 18.**

Justification - Over 75% of all smokers begin smoking by the age of 18.

B. **Ban the use of vending machine sales of tobacco products statewide in public places.**

Justification - 38% of 13 - 16 year olds, often purchase their cigarettes from a vending machine.

C. **Increase the excise tax on tobacco products and provide a portion of these tax revenues for the purpose of comprehensive health education, tobacco use behavior modification and cessation efforts.**

Justification - The price elasticity of tobacco products is in the range of -0.3 to -0.5. That means that a 10% increase in the price of cigarettes is expected to cause a 3% to 5% decline in tobacco consumption. Youth are at least as responsive to these changes as adults, and some evidence suggests that they may be significantly more responsive to price changes than adults.

D. **Enact a state law which restricts smoking in all public spaces, including government buildings, offices, shopping malls, restaurants, schools, buses, etc.**

Justification - Reinforces the social disapproval of tobacco use and acknowledges the scientific facts regarding the effects of environmental tobacco smoke on individual health. Also relieves the operator of the public space from liability in health related issues due to exposure to ETS.

E. **Establish a statewide youth education curriculum and cessation program for use in the public school system and post-secondary technical schools.**

Justification - Raises the awareness of youth in regards to tobacco advertising strategy, long-term use and associated health implications, the extreme addictive nature of the drug nicotine, and teaches strategies to decrease the probability of future use.

F. **Develop an ongoing annual statewide media campaign directed at the target audiences and participated in by a network of supporting agencies.**

Justification - Reinforces social disapproval of tobacco use, raises awareness of the underinformed in regards to tobacco use issues and lends support for change in the social milieu surrounding the use of tobacco products.

G. **Provide training, technical and financial support to statewide tobacco use health education and cessation efforts at the community level.**

Justification - To provide statewide leadership in an effort to guide the activities of communities within the framework of the State Tobacco Control Plan in a concerted fashion.

H. **Assist small business in developing worksite smoking policies.**

Justification - The state of Montana is composed of 98% small business, ie. businesses with fewer than 50 employees. Small businesses generally do not have the resources available to develop policy and provide services to employees who use tobacco products.

I. **Provide tobacco use health education and cessation referral materials to primary care physicians, dentists and respiratory therapists statewide.**

Justification - 85% of medical/dental patients say that they would attempt to quit if they received counseling and/or assistance from their health care provider.

J. **Provide smoking cessation in-service training to W.I.C. clinicians for use with their clients.**

Justification - Roughly 37% of W.I.C. clients (adult females) smoke cigarettes on a daily basis. Cigarette smoke is especially harmful to the developing fetus, newborn infant, young children and the mother herself.

CONCLUSION

With the release of the first Surgeon General's Report on Smoking and Health in 1964, the number of adult smokers peaked in the late 1960's and began a steady decline by the early 1970's. Currently the proportion of the American population who smoke has leveled off in most states, including Montana. Nearly thirty years has transpired since the release of the first Surgeon General's Report and the battle wages. However, the rules have changed drastically, and it is our youth and other selected special populations, who are using tobacco products in greater numbers than the general population. Most of the continuing activity is the result of the availability, advertising and addiction cycle. Youth in particular, are failing to acknowledge the known dangers of tobacco use, creating a very difficult niche of tobacco users to reach with control measures. The every day presence of tobacco company advertising and promotional campaigns appeal to the youth audience, managing to overpower and maintain control of this niche. For those of us who work in the area of tobacco control, it is difficult to understand why society has enacted such tight federal and state regulations on our food, drug, water and air supplies, yet allowed a substance as addictive and lethal as tobacco to remain completely unregulated, for the most part. Currently, tobacco is the only product on the American market which when used as intended, is highly addictive and kills. If we are to continue making progress toward the year 2000 objectives related to the use of tobacco products and the diseases associated, we must set forth a planned approach. Defining the key players in the tobacco control arena, planning the offensive game strategy and then activating a concerted effort to eliminate tobacco use from this state. This is what the Montana Tobacco Control Plan is all about. We encourage all interested parties to get involved in the planning and operation of this strategy. Taken together, the target groups selected, the channels activated, and the strategies implemented, will bring about changes in the usage patterns of tobacco in Montana.

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** **The framework for the Montana Tobacco Control Plan was developed from the ASSIST Program Guidelines for Tobacco-Free Communities which were developed by the National Cancer Institute and the American Cancer Society**